INFANT CASE MANAGEMENT CHARTING FORMS, 2006

This document provides information about the attached Infant Case Management (ICM) draft forms and restates documentation requirements for ICM referred to in the First Steps Documentation Requirements distributed in August, 2005. The purpose of the First Steps charting and documentation project is to:

- ensure a quality program that is standardized across the State of Washington
- implement a monitoring plan that can be delivered according to a uniform set of standards
- lay the groundwork for systematically collecting data and begin the process of standardizing outcomes recorded in client charts

In Maternity Support Services (MSS) the client is the mother whereas in ICM the client is the infant. ICM serves high risk infants and their families with family based services. Services may include assisting the biological parents' and/or immediate family issues or concerns as well as the infant's well being. ICM's goal is to improve self-sufficiency for the parent(s) in gaining access to needed medical, social, educational, and other services.

All information collected in the First Steps client charts is considered Personal Health Information (PHI). Although DOH and DSHS do not regulate how First Steps agencies organize their client charts, the First Steps state team highly recommends you keep separate charts for a mother and for her infant. This practice is in keeping with the fact that the parent and infant are two distinct individuals. The practice of separate charts for parent and infant protects confidentiality of both infant and parent(s).

ICM FORMS

Page 4 of this document lists all ICM forms for easy reference.

The business forms described in the August 2005 First Steps Documentation Requirements still apply during ICM. Please refer to that document for detailed descriptions of the following business forms needed during ICM: client registration; freedom of choice/consent for care; release of client information; and MSS/ICM billing information for agency business office. The forms below are specific to ICM charting:

- ICM Intake, DSHS form 13-658 (determines program eligibility)
- ICM Transition Questionnaire OR ICM New Client Screening Section I: Infant and Section II: Parent
- ICM Client Visit Record Section I: Infant and Section II: Parent
- ICM Plan for Care Section I: Infant and Section II: Parent
- ICM Outcome and Discharge Summary Section I: Infant and Section II: Parent

We arranged all but the ICM Intake form into two distinct sections, Section One for infants and Section Two for parents. This is an attempt to keep Personal Health Information and the confidential nature of that information separate for a parent and for the infant.

ICM Intake

After client eligibility is determined, First Steps providers can bill DSHS for ICM services. In order to bill, the infant has to have a Patient Identification Code (PIC) number as listed on the infant's DSHS medical ID card. Either the infant or parents must also meet at least one of the high risk criteria listed on the ICM Intake form.

A completed ICM Intake [DSHS 13-658 (REV. 06/2004)] must be present in the chart of each ICM client (infant). This intake form shows eligibility, and is done before the ICM client screening tool is completed.

Note on the ICM Intake form when an eligible family refuses ICM services or the client can not be located. File completed form in client chart according to agency record keeping protocols.

CLIENT SCREENING FORMS

Screening provides a method for reviewing and documenting major risk factors, areas of need or concern for the infant and/or family. Screening includes both a process for parent input and face to face interaction. The screening forms must be signed and dated in the spaces provided. Document all identified issues on the screening form(s) and place completed form in client chart according to agency record keeping protocols.

ICM Transitional Questionnaire:

For women seen in MSS whose family is now eligible for ICM, this form lists issues that will be the focus for ICM services. This questionnaire is intended to be filled out by the parent. With the screening information and information gathered from prior MSS visits, the ICM Plan for Care is developed.

-OR-

ICM New Client Screening:

For women NOT seen during the Maternity Support Services period, or for parents who are newly referred for ICM services, this form collects information not collected during MSS. This screening form is intended to be completed by the ICM staff and serves to document all aspects of the visit. There are two

sections to the New Client Screening form, Section One pertains to the infant and Section Two concerns parental issues. The screening form is designed to keep Personal Health Information for infant and parent separate.

If the screening cannot be completed in one visit, note the date of the second visit in the box at the top of the page in Section One Infant. Once the screening is completed, develop the ICM Plan for Care Infant and/or Parent based upon identified issues.

PLAN FOR CARE

A plan for care is required for ICM services. Agencies may use the ICM Plan for Care form or may use their own version. We encourage you to involve the parent(s) in developing the plan for care. The plan for care must be based upon information from the initial screening visit, and revised when significant changes occur or as information is identified. When completed, file the forms according to agency record keeping protocols.

ICM Plan for Care has two sections:

- Section One pertains to infant concerns, and
- Section Two is designed for parent issues.

DOCUMENTING CLIENT VISITS

ICM Client Visit Record (CVR):

Required for documenting client visits once the screening is completed. There are two sections to the form Section One pertains to the infant and Section Two is directed to parental issues. The top portion of Section One Infant must be completed for every visit. If the visit deals with parental issues exclusively, check the box “Refer to Parent Chart” on the bottom of page two of the CVR Infant section, and document those issues in Section Two Parents of the CVR. Once completed, file the forms according to agency record keeping protocols.

OUTCOME AND DISCHARGE SUMMARY

ICM Outcome and Discharge Summary:

Documents the family’s progress toward goals and/or outcomes related to the infant or family circumstances. It is completed upon termination of ICM services. All information in both the infant and parent sections must be completed.

GENERAL DOCUMENTATION REMINDERS

The following tips will improve the quality of your charts and will reduce problems when the First Steps state staff monitor your charts.

- Describe what is said and done concisely and efficiently
- Write clearly and legibly and be sure to sign your name or initials.
- Show progression from issue(s) identification, to inclusion in the plan for care, through client visit records, concluding with documented outcomes.
- Note reasons why issues are identified yet not addressed in the infant and/or parent chart.
- Note any discrepancies in information about infant or parent.

ELECTRONIC HEALTH RECORDS (EHR)

The First Steps Program encourages the use of electronic documentation. Agencies using electronic documentation are expected to adhere to the same standards outlined for paper documentation. The content of the required forms is required even if you use an electronic charting system.

If you have any questions or comments about this document or ICM in general, please contact Maureen Lally, First Steps Infant Program Manager at (360)-725-1655 or email lallyma@dshs.wa.gov.

COMPREHENSIVE LIST OF ICM FORMS FOR FIRST STEPS DOCUMENTATION

BUSINESS FORMS *– see First Steps Documentation Requirements dated August, 2005 for detailed description of each of the following forms:*

Client Registration
Freedom of Choice
Release of Client Information
Consent for Care
MSS/ICM Billing Information for Agency Business Office
Signature Log
Client Contact Log or MSS/ICM Contact Log and Service Tracking

CLINICAL CHARTING FORMS

ICM Intake – [DSHS 13-658 (REV. 06/2004)]
ICM Transition Questionnaire
or New Client Screening Section I: Infant and Section II: Parent
ICM Plan for Care Section I: Infant and Section II: Parent
ICM Client Visit Record Section I: Infant and Section II: Parent
ICM Outcome and Discharge Summary Section I: Infant and Section II: Parent

ICM Transition Questionnaire

(This form is only used with women who have received MSS and who are enrolling in ICM. File the completed form in parent chart.)

Your Baby's Name: _____ Birthday: _____

Your Name: _____ Birthday: _____

WELCOME TO INFANT CASE MANAGEMENT

(ALSO CALLED ICM)

An ICM case manager can help you find and use local services to help you take good care of your baby, yourself, and your family until your baby is one year old.

PLEASE CHECK ALL OF THE BOXES WHERE YOU WOULD LIKE HELP AND INFORMATION:

- ☐ Feeding by baby
- ☐ Taking care of my baby
- ☐ Helping my baby be healthy
- ☐ Adjusting to being a parent
- ☐ Being a good parent
- ☐ Finding childcare
- ☐ Keeping my baby and family safe
- ☐ Having a safe place to live
- ☐ Getting food for my family
- ☐ Getting clothes
- ☐ Going to appointments (like medical or dental)
- ☐ Riding the bus
- ☐ Not feeling sad, depressed, or lonely
- ☐ Having a healthy body
- ☐ Family planning
- ☐ Tobacco use and secondhand smoke
- ☐ Drug problems
- ☐ Alcohol problems
- ☐ Legal problems
- ☐ Getting a job
- ☐ Going to school
- ☐ Learning English
- ☐ Other: _____

If you have other concerns or issues that you would like more help with please write them below:

_____

_____

_____

THANK YOU FOR FILLING THIS OUT.
IT WILL HELP US HELP YOU BETTER.

DRAFT 02/06

ICM NEW CLIENT SCREENING SECTION I: INFANT

*This screening tool is for use only with clients who **did not** receive MSS services. Enter pertinent information from the ICM Intake form (DSHS 13-658 eligibility determination) into this tool.*

☐ Home Visit ☐ Office Visit ☐ Other _____ Present at Visit: _____

Date:_____ Time visit started: _____☐AM ☐PM Time visit ended: _____☐AM ☐PM

(If 2nd screening visit) Date: _____Time visit started _____ ☐AM ☐PM Time visit ended: _____☐AM ☐PM

Client (Infant) Name:_____ Date of Birth: _____

Infant's Mother's Name: _____ Mother's Date of Birth: _____

Infant's Father's Name (if involved): _____ Father's Date of Birth: _____

Infant's Health Care Provider: _____

Is your baby receiving Medical Coupons every month? ☐ Yes ☐ No PIC #: _____

On a Healthy Options Plan? ☐ Yes ☐No Which Plan? _____

Are you receiving other parenting support or case management services? ☐ Yes ☐ No _____

INFANT HEALTH AND DEVELOPMENT

1. Was your baby born premature? ☐Yes ☐No
   Gestation _____wks
2. Was your delivery ☐ Vaginal ☐ C-section?
3. Was your baby a twin/triplet/…? _____
4. Do you have any health conditions, such as ☐Hepatitis B, ☐HIV, ☐TB or ☐ Other _____? ☐ Yes ☐ No
5. If so, did you and your baby have follow-up medical care? ☐ Yes ☐ No
6. How much did your baby weigh at birth? _____
7. How long was he/she? _____
8. How much does your baby weigh now? _____
9. Did your baby have any health problems at the time of birth, or since s/he's been out of the hospital? ☐ Yes ☐ No
   _____
10. Has your baby had all recommended well child check-ups for his/her age? ☐ Yes ☐ No
11. Has your baby had all recommended immunizations for his/her age? ☐ Yes ☐ No
12. Are you having trouble getting health care for your baby? ☐ Yes ☐ No
13. Do you know how to protect your baby's mouth from disease? ☐ Yes ☐ No
14. How are you feeding your baby? ☐ Breastfeeding
    ☐ Formula: _____☐Both
15. Are you getting the breastfeeding support you need? ☐ Yes ☐ No
16. Are you feeding your baby anything besides breast milk or formula? _____ ☐ Yes ☐ No

NOTES:

_____

_____

☐ Other: _____

ACTIONS:

REINFORCED INFORMATION REGARDING:

☐ Well child health promotion
☐ Immunizations
☐ Nutrition

☐ Referred to oral health resources
☐ Referred for evaluation to the lead Family Resource Coordinator for access to Infant/Toddler Early Intervention Program and Services
☐ Referred to health care provider for well child visit
☐ Referred to health care provider for developmental concerns
☐ Referred to health care provider for medical concerns
☐ Facilitated appointment with health care provider
☐ Referred to WIC
☐ Referred to _____for breastfeeding support
☐ Advocated for client (with whom/for what):

_____

☐ Other: _____

COMPLETED BY: _____ _____

STAFF SIGNATURE **DATE**

BABY PATTERNS/CUES

17. What are your baby's sleep patterns? _____

_____

18. Are there times when your baby is usually alert? ☐ Yes ☐ No
19. Are there times when s/he's usually fussy? ☐ Yes ☐ No
20. Is your baby usually easy to calm down when s/he's fussy? ☐ Yes ☐ No
21. When your baby is crying, can you usually tell what s/he seems to need? ☐ Yes ☐ No
22. How would you describe your baby's personality (temperament)? _____
23. (If baby's father is involved) How does your baby's father describe your baby's personality (temperament)?

_____

24. Do you have any questions about the advice your family/friends give you about taking care of your baby?

_____
_____
_____

NOTES:

_____
_____
_____

ACTIONS:

REINFORCED INFORMATION REGARDING:
☐ Age-appropriate parenting strategies
☐ Bonding and attachment

☐ Referred to parenting class
☐ Advocated for client (with whom/for what):

_____

☐ Other: _____

COMPLETED BY:_____ _____
STAFF SIGNATURE **DATE**

BASIC FAMILY NEEDS

25. What is your living situation?
☐ Buying or ☐ Renting:
☐ house ☐ apartment ☐ room ☐other
Staying: ☐ with friends/family ☐ at a shelter
☐ in a car ☐ at a motel ☐ other
26. Does your family have enough money for food? ☐Yes ☐No
27. Are you on Food Stamps? ☐ Yes ☐ No ☐Applied
28. Are you employed? ☐ Yes ☐ No
29. Are you planning to go to work? ☐ Yes ☐ No
30. Is your partner employed? ☐ Yes ☐ No
31. Are you on Temporary Assistance to Needy Families (TANF)? ☐ Yes ☐ No ☐Applied
32. Do you have dependable transportation for medical appointments and other activities? ☐ Yes ☐ No
33. Do you need childcare? ☐ Yes ☐ No

NOTES: _____

_____
_____

ACTIONS:

☐ Gave housing resources list
☐ Gave information re: finding childcare

☐ Referred for housing _____
☐ Referred to DSHS
☐ Referred to WIC Agency: _____
☐ Referred to Food Bank *
☐ Referred for food stamps
☐ Referred to Employment Security
☐ Referred to:_____

COMPLETED BY:_____ _____
STAFF SIGNATURE **DATE**

Infant Name: _____ Infant Date of Birth: _____

Parent Name: _____ Parent Date of Birth: _____

NEXT STEPS

☐ **Develop Plan for Care based on issues identified in screening visit(s) and with input from parent.**

Next Appointment Date: _____

Notes (Optional): _____

_____

_____

_____

Staff Signature: _____ Date: _____

Infant Name: _____ Infant Date of Birth: _____

Parent Name: _____ Parent Date of Birth: _____

ICM NEW CLIENT SCREENING SECTION II: PARENT

(See infant chart for questions #1-33.)

☐ Home Visit ☐ Office Visit ☐ Other _____ Present at Visit: _____

SAFETY AND FAMILY ENVIRONMENT

34. Is your baby exposed to 2nd hand smoke? ☐ Yes ☐ No
35. Do you have smoke detectors in your home? ☐ Yes ☐ No
36. Have you checked them, and do they work? ☐ Yes ☐ No
37. Do you have weapons in your home? ☐ Yes ☐ No
38. Are your weapons secured? ☐ Yes ☐ No
39. Do you have a safe car seat for your child? ☐ Yes ☐ No
40. Have you been trained in infant CPR? ☐ Yes ☐ No
41. Are you afraid of your partner? ☐ Yes ☐ No
42. Has your partner ever put you down, said hurtful things, or threatened you? ☐ Yes ☐ No
43. Has your partner ever pushed, hit, kicked, or physically hurt you? ☐ Yes ☐ No
44. Has your partner ever threatened or forced you to have sexual contact? ☐ Yes ☐ No
45. Is there someone else you're afraid of? ☐ Yes ☐ No
46. Do you worry about somebody mistreating you? ☐Yes ☐ No
47. Do you worry about anyone mistreating your child / children? ☐Yes ☐No

NOTES:

_____

_____

☐ Has a safety plan

ACTIONS:

☐ Helped client develop a plan for keeping child free from 2nd hand smoke exposure
☐ Assisted with a safety plan
☐ Gave gun safety handout
☐ Gave gun lock
☐ Gave information re: car seat safety
☐ Gave car seat resources
☐ Gave car seat
☐ Gave safety check list
☐ Gave info re: CPR training resources
☐ CPS discussed
☐ CPS report made
☐ Referred to _____ (for smoke alarm)
☐ Referred to DV services: _____
☐ Referred to sexual assault services:_____

COMPLETED BY:_____ _____
STAFF SIGNATURE **DATE**

PARENTAL STRESS / COPING / SOCIAL SUPPORT

48. Have you / your partner *(circle)* ever had legal problems? ☐ Yes ☐No
49. Have you / partner *(circle)* ever been in jail? ☐Yes ☐No
50. Who can you count on for help / support?
_____
51. Who can you talk with about stressful things in your life?
_____
52. What are some of the ways you cope with stress?
_____
53. How well do these things work for you? (*circle one)*
Not at all ……..…..OK……Very well
54. When problems come up in your life, how do you feel about your ability to handle them? *(circle one)*
I usually need: A lot of help…….Some help……..No help
55. What are some of the ways you deal with anger? (yours / other people's)
_____
56. How well do they work for you? *(circle one)*
Not at all ……OK…… Very well ……..

NOTES:

_____

_____

ACTIONS:

REINFORCED INFORMATION REGARDING:
☐ Strategies for coping with stress
☐ Importance of support system
☐ Self care and coping
☐ Ways to increase support
☐ Referred to legal advocacy resource: _____
☐ Referred to _____

COMPLETED BY: _____ _____
STAFF SIGNATURE **DATE**

Infant Name: _____ Infant Date of Birth: _____

Parent Name: _____ Parent Date of Birth: _____

PARENTAL HEALTH CONDITIONS / DEVELOPMENTAL ISSUES / MENTAL HEALTH / SUBSTANCE USE

57. Have you ever used tobacco? ☐ Yes ☐ No
58. Do you use tobacco now? ☐ Yes ☐ No
59. Are you thinking about starting to smoke again? ☐ Yes ☐ No
60. Are you exposed to 2nd hand smoke? ☐ Yes ☐ No
61. Are you using birth control? ☐ Yes ☐ No
62. Do you have any health conditions? ☐ Yes ☐ No
    Condition: _____
63. Do you have any concerns about your weight? ☐ Yes ☐ No
64. Are your immunizations up to date? ☐ Yes ☐ No
    ☐ Don't know
65. Have you had a dental check-up in the last yr? ☐ Yes ☐ No
66. Do you have broken/decayed teeth? ☐ Yes ☐ No
67. What regular exercise do you do and how often?
    _____
68. In school, were/are there subjects/skills (i.e., reading) that were/are very hard for you to learn? ☐ Yes ☐ No
    _____
69. Were/are you in Special Education classes? ☐ Yes ☐ No
70. Are you or is someone else concerned about your mental health? ☐ Yes ☐ No
71. Have you ever had mental health counseling? ☐ Yes ☐ No
72. Have you ever been treated for depression? ☐ Yes ☐ No
73. Over the past 2 weeks, have you felt:
    Sad, depressed, crying without knowing why? ☐ Yes ☐ No
    Scared, worried, irritable for no good reason? ☐ Yes ☐ No
    Unable to enjoy things you usually enjoy? ☐ Yes ☐ No
    Unable to see the funny side of things as you usually can? ☐ Yes ☐ No
    Hopeless, feeling things won't get better? ☐ Yes ☐ No
74. Have you had any thoughts of hurting yourself or the baby? ☐ Yes ☐ No
75. Are you taking medications for mental health reasons? ☐ Yes ☐ No _____
76. Has anyone in your family ever had any problems with drugs or alcohol? ☐ Yes ☐ No
77. Have you used alcohol / drugs *(circle)* just before or during your pregnancy? ☐ Yes ☐ No
78. Has anyone ever told you they were worried about your alcohol / drug use *(circle)*? ☐ Yes ☐ No
79. Have you ever had any problems with drugs or alcohol? ☐ Yes ☐ No
80. Has someone you live with ever had any problems with drugs or alcohol *(circle)*? ☐ Yes ☐ No

NOTES:

_____

_____

ACTIONS:

REINFORCED INFORMATION REGARDING:

☐ Tobacco/ 2nd hand smoke
☐ Family Planning
☐ Postpartum mood disorders

☐ Referred for Special Education Services
☐ Referred for DDD services
☐ Referred to MD for health condition
☐ Referred to _____ for assistance with family planning
☐ Referred to oral health resources
☐ Facilitated oral health/medical appointment
☐ Referred to mental health services
☐ Assisted in obtaining mental health services
☐ Referred to substance abuse services
☐ Assisted in obtaining substance abuse treatment services
☐ Referred to AA
☐ Referred to Al Anon
☐ Referred to NA
☐ Referred ADATSA
☐ Advocated for client (with whom/for what): _____
_____

☐ Other _____

COMPLETED BY: _____ _____
STAFF SIGNATURE **DATE**

Infant Name: _____ Infant Date of Birth: _____

Parent Name: _____ Parent Date of Birth: _____

OTHER AREAS OF NEED

81. Are there any specific things you would like help with?

☐ Yes ☐ No

82. If so, what are they?

NOTES:

_____

_____

☐ History of physical/sexual abuse

ACTIONS:

☐ Referred to _____

COMPLETED BY: _____ _____

STAFF SIGNATURE

DATE

NEXT STEPS

☐ **Develop Plan for Care based on issues identified in screening visit(s) and with input from parent.**

Next Appointment Date: _____

Notes (Optional): _____

_____

_____

_____

Staff Signature: _____ Date: _____

Infant Name: _____ Infant Date of Birth: _____

Parent Name: _____ Parent Date of Birth: _____

ICM PLAN FOR CARE Section I: Infant

Referral: *Providing information to clients that will assist them in receiving medical, social, educational, or other services.*

Linkage: *Networking and/or collaboration between staff of different agencies or across programs in order to connect clients to services and avoid duplication.*

Advocacy: *Acting on the client's behalf in order to ensure the client receives needed services.*

DATE IDENTIFIED & STAFF INITIALS	AREA OF FOCUS	PLAN OF ACTION (DATE IF REVISING)
	☐ **INFANT HEALTH AND DEVELOPMENT** ☐ Premature birth ☐ Low birth weight ☐ Failure to thrive ☐ Excessive fussiness ☐ Identified medical condition ☐ Identified developmental delay ☐ Well Child Exams/Immunizations ☐ Other	☐ REFERRAL (WITH WHOM/FOR WHAT): _____ ☐ ADVOCACY/LINKAGE (WITH WHOM/FOR WHAT): _____ ☐ OTHER: _____
	☐ **PARENTING SUPPORT** ☐ Parenting support ☐ Parenting skills ☐ Other	☐ REFERRAL (WITH WHOM/FOR WHAT): _____ ☐ ADVOCACY/LINKAGE (WITH WHOM/FOR WHAT)**:** _____ ☐ OTHER:
	☐ **BASIC FAMILY NEEDS** ☐ Unstable living conditions ☐ Food availability ☐ Lack of resources ☐ Child Care ☐ Other	☐ REFERRAL (WITH WHOM/FOR WHAT): _____ ☐ ADVOCACY/LINKAGE (WITH WHOM/FOR WHAT)**:** _____ ☐ OTHER:
	☐ **OTHER AREAS OF NEED FOR INFANT**	☐ REFERRAL (WITH WHOM/FOR WHAT): _____ ☐ ADVOCACY/LINKAGE (WITH WHOM/FOR WHAT)**:** _____ ☐ OTHER: _____

NOTES: _____
_____
_____

Infant Name: _____ Infant Date of Birth: _____

Parent Name: _____ Parent Date of Birth: _____

ICM PLAN FOR CARE Section II: Parent

Referral: *Providing information to clients that will assist them in receiving medical, social, educational, or other services.*

Linkage: *Networking and/or collaboration between staff of different agencies or across programs in order to connect clients to services and avoid duplication.*

Advocacy: *Acting on the client's behalf in order to ensure the client receives needed services.*

DATE IDENTIFIED & STAFF INITIALS	AREA OF FOCUS	PLAN OF ACTION (DATE IF REVISING)
	☐ **SAFETY AND FAMILY ENVIRONMENT** ☐ Domestic/family violence ☐ Secondhand smoke ☐ CPS involvement ☐ Past termination of parental rights ☐ Other	☐ REFERRAL (WITH WHOM/FOR WHAT): _____ ☐ ADVOCACY/LINKAGE (WITH WHOM/FOR WHAT): _____ ☐ OTHER:
	☐ **PARENTAL STRESS / COPING / SOCIAL SUPPORT** ☐ Strategies for coping and self-care ☐ Significant parental sleep deprivation ☐ Parental incarceration ☐ Social isolation ☐ Language or cultural barriers ☐ Other	☐ REFERRAL (WITH WHOM/FOR WHAT): _____ ☐ ADVOCACY/LINKAGE (WITH WHOM/FOR WHAT): _____ ☐ OTHER:
	☐ **PARENTAL HEALTH CONDITIONS/DEVELOPMENTAL ISSUES/MENTAL HEALTH/SUBSTANCE USE** ☐ Physical health condition ☐ Developmental disability ☐ Family planning ☐ Tobacco ☐ Mental health condition or mood disorder ☐ Substance use ☐ Other	☐ REFERRAL (WITH WHOM/FOR WHAT): _____ ☐ ADVOCACY/LINKAGE (WITH WHOM/FOR WHAT): _____ ☐ OTHER:
	☐ **OTHER AREAS OF NEED FOR PARENT/FAMILY**	☐ REFERRAL (WITH WHOM/FOR WHAT): _____ ☐ ADVOCACY/LINKAGE (WITH WHOM/FOR WHAT): _____ ☐ OTHER:

NOTES:_____

_____

_____

Infant Name: _____ Infant Date of Birth: _____

Parent Name: _____ Parent Date of Birth: _____

ICM CLIENT VISIT RECORD Section I: Infant

Infant Name: _____ Date of Birth: _____ Visit Date: _____

Parent Name: _____ Date of Birth: _____

☐ HV ☐ OV Present at visit: _____

Time visit started: ☐ AM ☐ PM Time visit ended: ☐ AM ☐ PM

Referral: *Providing information to clients that will assist them in receiving medical, social, educational, or other services.*

Linkage: *Networking and/or collaboration between staff of different agencies or across programs in order to connect client to services and avoid duplication.*

Advocacy: *Acting on the client's behalf in order to ensure the client receives needed services.*

FOLLOW-UP FROM LAST VISIT	Parent has Plan	Plan in progress	Received / Completed	**ACTION TAKEN TODAY**	**LINKAGES AND/OR NOTES ON PROGRESS WITH PLAN FOR CARE**
INFANT HEALTH AND DEVELOPMENT					
Well Child Care	☐	☐	☐	**REINFORCED INFORMATION REGARDING:** ☐ Well child health ☐ Immunizations appropriate for infant age ☐ Normal growth and development	
Early Childhood Development	☐	☐	☐		
2nd Hand Smoke Exposure	☐	☐	☐	☐2nd hand smoke exposure	
Nutrition	☐	☐	☐	☐ Nutrition/feeding information	
				REFERRAL/ADVOCACY	
Oral Health	☐	☐	☐	☐ Referred to oral health resources	
Health Care Provider	☐	☐	☐	☐ Referred to health care provider for well child visit	
Infant/Toddler Early Intervention Program (ITEIP)	☐	☐	☐	☐ Referred to health care provider for infant medical concerns – Specific Condition(s):_____ _____	
Other	☐	☐	☐	☐ Referred to health care provider for developmental concerns ☐ Referred for evaluation to the lead Family Resources Coordinator for access to Infant/ Toddler Early Intervention Program (ITEIP)	
				☐ Advocated for client (with whom/for what): _____ _____	
				☐ Other: _____	

Staff Initials: _____

FOLLOW-UP FROM LAST VISIT	Parent has Plan Plan in progress Received / Completed	**ACTION TAKEN TODAY**	**LINKAGES AND/OR NOTES ON PROGRESS WITH PLAN FOR CARE**
PARENTING			
Parenting Class ☐ ☐ ☐ Other ☐ ☐ ☐		**REINFORCED INFORMATION REGARDING:** ☐ Age-appropriate parenting strategies ☐ Bonding and attachment **REFERRAL/ADVOCACY** ☐ Referred to parenting class ☐ Advocated for client (with whom/for what): _____ _____ ☐ Other: _____	
BASIC FAMILY NEEDS			
WIC ☐ ☐ ☐ DSHS / CSO ☐ ☐ ☐ Food Bank ☐ ☐ ☐ Employment Security ☐ ☐ ☐ Housing resources ☐ ☐ ☐ Clothing resources ☐ ☐ ☐ Education resources ☐ ☐ ☐ Childcare resources ☐ ☐ ☐ Transportation ☐ ☐ ☐ Other ☐ ☐ ☐		**REFERRAL/ADVOCACY** ☐ WIC ☐ DSHS / CSO ☐ Food Bank ☐ Employment Security ☐ Housing resources ☐ Clothing resources ☐ Education resources _____ ☐ Childcare resources ☐ Transportation resources ☐ Advocated for client (with whom/for what): _____ _____ ☐ Other:_____	
OTHER AREAS OF NEED RELATING TO INFANT:			

Next Steps: _____

_____

☐ Refer to Parent Chart

Infant Name: _____ Infant Date of Birth: _____

Parent Name: _____ Parent Date of Birth: _____

Staff Initials: _____ Date: _____ Next appt. _____

ICM CLIENT VISIT RECORD Section II: Parent

Infant Name: _____ Date of Birth: _____ Visit Date: _____

Parent Name: _____ Date of Birth: _____

☐ HV ☐ OV Present at visit: _____

Time visit started: ☐ AM ☐ PM Time visit ended: ☐ AM ☐ PM

Referral: *Providing information to clients that will assist them in receiving medical, social, educational, or other services.*

Linkage: *Networking and/or collaboration between staff of different agencies or across programs in order to connect client to services and avoid duplication.*

Advocacy: *Acting on the client's behalf in order to ensure the client receives needed services.*

FOLLOW-UP FROM LAST VISIT	**Parent has Plan / Plan in progress / Received / Completed**	**ACTION TAKEN TODAY** REFERRAL AND ADVOCACY	**LINKAGES AND/OR NOTES ON PROGRESS WITH PLAN FOR CARE**
SAFETY AND FAMILY ENVIRONMENT			
Working Smoke Alarm ☐☐☐ CPS ☐☐☐ DV ☐☐☐ Weapons Secured ☐☐☐ Car Seat ☐☐☐ Other ☐☐☐		**REINFORCED INFORMATION REGARDING:** ☐ SIDS/Back to sleep ☐ CPR/First Aid ☐ Risks of 2nd hand smoke ☐ Car seat safety ☐ Shaken baby syndrome ☐ Smoke alarm ☐ **REFERRAL/ADVOCACY** ☐ Referred for gun locks ☐ Referred to DV services ☐ Assisted in obtaining DV services ☐ CPS discussed/Report made ☐ Advocated for client (with whom/for what): _____ _____ ☐ Other	
PARENTAL STRESS / COPING / SOCIAL SUPPORT			
Self-care ☐☐☐ Coping and Stress ☐☐☐ Support System ☐☐☐ Legal Advocacy ☐☐☐ Other ☐☐☐		**REINFORCED INFORMATION REGARDING:** ☐Self-care and coping ☐Strategies for coping with stress ☐Ways to increase support system ☐Importance of support system **REFERRAL/ADVOCACY** ☐ Referred to legal advocacy resource: _____ ☐ Advocated for client (with whom/for what): _____ _____ ☐ Other:	

Staff Initials: _____

FOLLOW-UP FROM LAST VISIT	Parent has Plan	Plan in progress Received / Completed	**ACTION TAKEN TODAY** REFERRAL AND ADVOCACY	**LINKAGES AND/OR NOTES ON PROGRESS WITH PLAN FOR CARE**
PARENTAL HEALTH CONDITIONS / DEVELOPMENTAL ISSUES / MENTAL HEALTH / SUBSTANCE USE				
Quit Line ☐ ☐ ☐ Fax Back ☐ ☐ ☐ Family Planning ☐ ☐ ☐ Mental Health Services ☐ ☐ ☐ AA ☐ ☐ ☐ Al Anon ☐ ☐ ☐ NA ☐ ☐ ☐ Treatment ☐ ☐ ☐ Oral Health Services ☐ ☐ ☐ Health Care Provider ☐ ☐ ☐ Other ☐ ☐ ☐			**REINFORCED INFORMATION REGARDING:** ☐ Tobacco/ 2nd hand smoke ☐ Family Planning ☐ Mental health service options ☐ Postpartum mood disorders **REFERRAL/ADVOCACY** ☐ Referred to Quit Line via Fax Back ☐ Referred to health care provider for medical concerns re: Mom - Specific Condition(s) _____ _____ ☐ Referred to _____ for assistance with family planning ☐ Referred to oral health resources ☐ Facilitated oral health/medical appointment ☐ Assisted in obtaining mental health services ☐ Assisted in obtaining substance abuse treatment services ☐ Referred to AA ☐ Referred to Al Anon ☐ Referred to NA ☐ Advocated for client (with whom/for what): _____ _____ ☐ Other	
OTHER AREAS OF NEED RELATING TO PARENT/FAMILY:				

Next Steps: _____

_____

_____

Infant Name: _____ Infant Date of Birth: _____

Parent Name: _____ Parent Date of Birth: _____

Staff Initials: _____ Date: _____ Next appt. _____

ICM Outcome and Discharge Summary Section I: Infant

Infant Name/Birthdate: _____

Parent Name/Birthdate: _____

Date Discharged from ICM: _____

Reason for discharge from ICM:

☐ Parent discontinued services ☐ No longer eligible
☐ Transferred to different agency ☐ Lost to follow-up
☐ Services completed ☐ Family relocated
☐ Other: _____

Area of Focus and Action / Information	**Client Outcome Information**						
	Check the appropriate box to the right; if answer is not "Yes", provide a brief explanation.	Yes	Sometimes	No	Unknown	Not applicable
☐ **Infant Health and Development** ☐ Assisted in obtaining appropriate nutrition services ☐ Referred to _____for growth concerns ☐ Referred to _____for medical/health concerns ☐ Referred to Infant/Toddler Early Intervention Program (ITEIP)	**Infant received well child check-ups:** _____ _____	☐	☐	☐	☐	☐
	Infant received immunizations: _____ _____	☐	☐	☐	☐	☐
	Infant received recommended medical treatment: _____ _____	☐	☐	☐	☐	☐
	Parent appropriately cared for infant's oral health: _____ _____	☐	☐	☐	☐	☐
	Parent protected infant from 2nd hand smoke: _____ _____	☐	☐	☐	☐	☐
	Infant's growth and/or development was ○below ○within ○above standard guidelines. _____ _____					
	Feeding concerns were resolved: _____ _____	☐	☐	☐	☐	☐
	Infant is put to bed without bottle: _____ _____	☐	☐	☐	☐	☐

AREA OF FOCUS AND ACTION / INFORMATION	CLIENT OUTCOME INFORMATION					
	Check the appropriate box to the right; if answer is not "Yes", provide a brief explanation.	Yes	Sometimes	No	Unknown	Not applicable
☐ **PARENTING** ☐ Assisted with enrollment in parenting class ☐ Assisted with obtaining services from _____ ☐ Referred to _____ for assistance with bonding	**Parent demonstrated age-appropriate parenting strategies:** _____ _____	☐	☐	☐	☐	☐
	Positive Parent/Baby bond was evident: _____ _____	☐	☐	☐	☐	☐
☐ **BASIC FAMILY NEEDS** ☐ Assisted in obtaining appropriate services	**Housing situation improved:** _____ _____	☐	☐	☐	☐	☐
	Income situation improved: _____ _____	☐	☐	☐	☐	☐
	Food situation improved: _____ _____	☐	☐	☐	☐	☐
	Childcare situation improved: _____ _____	☐	☐	☐	☐	☐
☐ **OTHER AREAS OF NEED FOR INFANT:**						

Discharge Comments (*optional*): _____

_____

_____

Staff Signature: _____ Date: _____

Infant Name: _____ Infant Date of Birth: _____

Parent Name: _____ Parent Date of Birth: _____

ICM Outcome and Discharge Summary Section II: Parent

Infant Name/Birthdate: _____

Parent Name/Birthdate: _____

Date Discharged from ICM: _____

Reason for discharge from ICM:
☐ Parent discontinued services ☐ No longer eligible
☐ Transferred to different agency ☐ Lost to follow-up
☐ Services completed ☐ Family relocated
☐ Other: _____

Area of Focus and Action Information	**Parent Outcome Information**					
	Check the appropriate box to the right; if answer is not "Yes", provide a brief explanation.	Yes	Sometimes	No	Unknown	Not applicable
☐ **Safety and Family Environment** ☐ Assisted in obtaining appropriate safety products and services	**Parent reports using infant car seat:** _____ _____	☐	☐	☐	☐	☐
	Parent reports putting infant on back to sleep: _____ _____	☐	☐	☐	☐	☐
	Parent reports that pet safety is practiced: _____ _____	☐	☐	☐	☐	☐
	Parent reports domestic safety improved: _____ _____	☐	☐	☐	☐	☐
☐ **Parental Stress/Coping/ Social Support** ☐ Assisted in obtaining appropriate services	**Self care and coping abilities improved:** _____ _____	☐	☐	☐	☐	☐
	Support system improved: _____ _____	☐	☐	☐	☐	☐

AREA OF FOCUS AND ACTION INFORMATION	PARENT OUTCOME INFORMATION					
	Check the appropriate box to the right; if answer is not "Yes", provide a brief explanation.	Yes	Sometimes	No	Unknown	Not applicable
☐ **PARENTAL HEALTH CONDITIONS/DEVELOPMENTAL ISSUES/MENTAL HEALTH/ SUBSTANCE USE** ☐ Assisted in obtaining family planning services ☐ Assisted in obtaining mental health services ☐ Assisted in obtaining tobacco cessation/substance abuse treatment services ☐ Assisted in obtaining oral health services	**Parent reports no tobacco use:** _____ _____	☐	☐	☐	☐	☐
	Parent reports no substance use: _____ _____	☐	☐	☐	☐	☐
	Parent reports no exposure to 2nd hand smoke: _____ _____	☐	☐	☐	☐	☐
	Parent reports using contraception: _____ _____	☐	☐	☐	☐	☐
	Postpartum mood disorders improved: _____ _____	☐	☐	☐	☐	☐
☐ **OTHER AREAS OF NEED FOR PARENT/FAMILY:**						

Client satisfaction survey sent: ☐ Yes ☐ No

Discharge Comments (optional):

_____

_____

_____

_____

_____

Staff Signature: _____ Date: _____

Infant Name: _____ Infant Date of Birth: _____

Parent Name: _____ Parent Date of Birth: _____